SECTION THREE CONGREGATE CARE

I. CORE STANDARDS FOR CONGREGATE CARE

Residential Treatment Facility (RTF) or Level II Group Care

A. General Characteristics

Congregate care is designed to meet the needs of children who are unable to live at home or in a Resource Family and require temporary care in a group or residential setting. Congregate care provides structure, counseling/therapy, behavioral intervention and other services identified in a child's permanency plan for children with moderate to severe clinical needs

Goals/discharge criteria for Children in Congregated care:
Permanency through reunification, kinship care, adoption, or guardianship.

B. Admission/Clinical Criteria

1. The service is available to children—regardless of adjudication type—whose relationship with their families or whose family situation, level of development, and social or emotional problems are such that services in a family setting would not meet the child's treatment needs due to supervision, intervention, and/or structure needs.
2. Programs are designed for youth in need of twenty-four hour care and integrated planning addressing behavioral, emotional, or family problems and the need for progressive reintegration into family and community living.

C. Personnel

1. Adequate care and supervision is provided at all times to assure that children are safe and that their needs are met, in accordance with their developmental level, age, and emotional or behavioral problems, and include
   a. See each respective service category for staff-to-children. ratios;
   b. higher adult/child ratios during periods of greater activity;
   c. availability of additional or back up direct care staff for emergency situations or to meet special needs presented by the children in care
2. No more than five (5) experienced providers of case coordination or casework service report to one (1) supervisor.
3. The case loads for personnel providing case coordination or casework services do not exceed fifteen (15) residents, and may be adjusted according to current case responsibilities.
4. No more than seven (7) experienced direct care staff members report to one supervisor and the ratio is reduced to one to five when the workers are inexperienced.

D. Service Components within the per diem

1. Planning for stability and permanence in the care and provision of services to each child includes:
   a. engagement of the child's parents in the placement and planning process,
   b. ongoing efforts to obtain parental participation in services,
   c. assistance to the child's parents in resolving problems that necessitated the child's removal,

d. retention of the maximum feasible family involvement in the decision-making and maintenance of contact between the family and child (unless clearly contraindicated by the Child and Family Team), and

e. assistance with recruitment of an adoptive or a long-term resource family, if indicated by the child's permanency plan.

2. Depending on the needs of the children in care, the services of qualified professionals in various mental health disciplines, consultants and specialists in dentistry, medicine, nursing, education, speech, occupational and physical therapy, recreation, dietetics, and religion are available among the agency's personnel or through cooperative arrangements, and are integrated with the core services of the agency to provide a comprehensive program. Basic services include but are not limited to the following and are based on the child's individual needs.

E. Education of the Child/Youth

1. Students in residential programs licensed as **Family Boarding Homes** or **Maternity Homes** typically attend public school.
2. Students in residential programs licensed as **Group Care Homes, Child Placing Agencies, and Residential Child Care Agencies** may attend public school. Regions and providers must work collaboratively through the CFTM process to determine placement options for a child/youth with zero tolerance needs. The DCS Education Specialist MUST be included in the CFTM.
3. Students in residential programs licensed as **Residential Treatment Facilities, Mental Health Hospital Facilities, Residential Rehabilitation Treatment Facilities or Mental Retardation Residential Habilitation Facilities** must have an approved in-house school site available for students.

   (For additional licensure information, see Section 9, Attachment 8, titled *Licensure Matrix.)*
4. Providers should meet all criteria outlined in Section 9, Attachment 9, *titled Educational Standards for DCS Providers.*

F. Monitoring Progress

1. Agency programs must examine the need for and appropriateness of service for clients through a Child and Family Team Meeting, at least quarterly or as determined by the team, reviewing
   a. continued out-of-home care,
   b. efforts for family reunification, and
   c. the adequacy of efforts to preserve and continue the parent/child relationship when possible and in the child's interest.
2. The agency must participate in any other reviews deemed necessary by DCS or the courts.
3. The agency must participate fully with Program Accountability and Review monitoring.
4. The agency will respond and provide immediately required documentation as requested by TennCare Consumer Advocate (TCCA) or Tennessee Alliance for Legal Services (TALS).

G. Utilization Review

The agency shall participate in a monthly Utilization Review (UR) with DCS. UR is a process for reviewing the clinical and educational needs and behaviors of each child/youth to determine the continuing need for services and efforts toward achieving permanency in a timely manner.

H. Discharge Criteria

Children/youth will be discharged in compliance with CFTM protocol.

II. LEVEL II GROUP CARE FACILITIES

A. General Characteristics

1. Level II Group Care Facilities are designed to meet the needs of children who are unable to live at home, or with a Resource Family, and therefore require temporary care in a group care setting integrated within the community;
2. The Group Care Facility provides structure, therapeutic support, behavioral intervention and other services identified in a child's permanency plan for children with low to moderate clinical and behavioral needs.
3. Goals/discharge criteria for Children in Level II Group Care typically include permanency through reunification, kinship care, adoption or guardianship;
4. Group Care Facilities are licensed by DCS and may be licensed individually as Family Boarding Homes, Group Care Homes or Maternity Homes. They may also be licensed collectively as a Child Placing Agency through any combination of these programs administered by a single entity;
5. Group Care Facilities may also be licensed as DCS Residential Child Care Agencies if they serve a population consisting of more than twelve (12) youth (including collective populations on contiguous properties). Unlike other Group Care Facilities, DCS Residential Child Care Agencies may not be approved under a DCS Child Placing Agency License.

B. Admission/Clinical Criteria

Child/youth will present with previously mentioned needs/behaviors. The following criteria must be met for admission to a Level 2 group home:

1. The service is available to child/youth—regardless of adjudication type—whose relationship with their families or whose family situation, level of development and social or emotional problems are such that services in a family setting would not meet the child/youth's treatment needs due to supervision, intervention and/or structure needs;
2. Programs are designed for child/youth in need of twenty-four (24) hour care and integrated planning to address behavioral, emotional, or family problems and the need for progressive reintegration into family and community living. Children/youth in Level II group home placement remain involved in community-based schools (if appropriate) and participate in community-based recreational activities with appropriate supervision;
3. Children/youth may have a history of truancy but are typically able to attend public school with liaison and support services provided by the agency;

4. Child/youth may have a history of impulsive behaviors, aggression and alcohol or drug misuse. The child/youth may also be appropriate for these Group Care programs if displaying, moderate to low sexually reactive behaviors. In addition, the child/youth has been treated at a higher level of care for sexually reactive behavior or sex offender issues and has been assessed with a low to moderate risk for reoffending. Child/youth may have patterns of runaway episodes, have difficulty maintaining self-control, display poor social skills and/or have difficulty accepting authority;
5. Child/youth in this level of care have behaviors that can be treated in a non-secure setting, with adult supervision and intervention;
6. Child/youth may have completed higher levels or intensity of care and determined appropriate for group placement as work toward permanency continues;
7. Child/youth in this level of care may require community counseling or therapy, medication and medication management. These services shall be coordinated by the agency and integrated into Treatment Planning;
8. Child/Youth with a primary diagnosis of mental retardation is evaluated on a case-by-case basis. Child/Youth with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation are not appropriate unless the agency is licensed for this service type;
9. Child/youth who are ineligible for this level of care are those who have need of acute psychiatric hospitalization and/or require incarceration for major acts of violence or aggression within the past six (6) months. Those who are found to pose a significant risk to the community are not appropriate for this level of care.

C. Assessment Requirements

1. The program must ensure that the following assessments are completed prior to development of the child/youth's Treatment Plan:
   a. Assessments current functioning, and a history in the following areas:
      1. Community living skills;
      2. Living skills appropriate to age;
      3. Emotional , psychological health; and,
      4. Education level (including educational history);
   b. Basic medical history and information;
   c. A six (6) month history of prescribed medication(s), frequently used over-the-counter medication and alcohol or other drug use;
   d. History of prior mental health and alcohol and drug treatment episodes; and,
   e. Assessment of whether child/youth is currently eligible for special education services in accordance with the State Board of Education Rules, Regulations and Minimum Standards.
   f. Child and Adolescent Needs & Strengths (CANS) shall be used as a screening tool for children and youth to assist with determination if residential treatment is indicated. Prior to the CFTM, the CANS (if available) should be thoroughly reviewed so the team will have the recommendation available for consideration in placement-related decisions;

g. Youth Level of Services (YLS**)** - Juvenile Justice Youth at this level of service may have low, medium or high YLS risk levels. Youth may be appropriate for admission at this level of care following classification at a Youth Development Center or Assessment Center.

h. Provider is required to accept all referrals for children deemed to meet the need for this level of service unless the provider is at full capacity or if the provider has justified clinical documentation that indicates either a higher level of care or a Youth Development Center (YDC) placement is more appropriate. Such a scenario will require either the region or the provider to file an appeal under the CFTM appeals process.

D. Personnel & Staffing Requirements

1. Adequate care and supervision is provided to assure that child/youth is safe and that his/her needs are met, in accordance with child/youth's developmental level, age and emotional or behavioral problems, and include:
   a. at least one (1) on-duty child care worker providing continuous supervision for each group of eight (8) children or youth (staff to student ratio of 1:8). This ratio is also maintained at night;
   b. higher adult/child ratios during periods of greater activity is recommended; and,
   c. availability of additional or back-up direct care staff for emergency situations or to meet special needs presented by the children in care as needed.
2. No more than five (5) providers of case coordination or casework services report to one (1) supervisor.
3. No more than seven (7) direct care staff members report to one (1) supervisor and the ratio is reduced to 1:5 when the workers are newly hired or in probationary status;
4. The case loads for personnel providing case coordination or casework services do not exceed fifteen (15) residents.

E. Individualized Treatment Plan

1. An Individualized Treatment Plan must be developed and implemented for each child/youth. An initial assessment of the child/youth's needs and strengths must be completed within 72 hours of admission. The information gleaned from the assessment can be incorporated into the Treatment Plan. Detailed guidelines for the Treatment Plan are listed in the Core Standards of the Provider Policy Manual.

F. Service Overview

The agency will provide a program of group living experiences and a program of specialized services for each child/youth accepted into care.

G. Service Components

1. Services provided by the agency include but are not limited to:
   a. Individualized Treatment Plan, including structured behavioral assessment and intervention services as needed to meet the child/youth's treatment goals;
   b. Structured individual or group treatment activities and/or process groups, including the development of resiliency for emotional and behavioral conditions;
   c. Alcohol and drug awareness education;

d. Individual, group and/or family therapeutic support provided by trained and supervised staff;
e. Case management and coordination, including support of the DCS Permanency Plan and participation in the Child and Family Team;
f. Coordination of medically necessary individual therapy accessed in the community, including specialized therapy for sexually reactive behaviors and alcohol and drug abuse;
g. Note that community-based medically necessary individual therapy may be accessed through TennCare for children/youth who are TennCare eligible;
h. Coordination of health services, including arranging and accessing community based medically necessary health services through TennCare and private insurance:
    i. TennCare provides all medically necessary health services;
    ii. EPSDT and EPSDT Dental screenings must be arranged and accessed according to DCS policy (20.7; 20.12); and,
    iii. Agencies will provide communication of all required and received health services to the DCS Regional Services and Appeals Tracking (SAT) Coordinator by submission of the Health Services Confirmation and Follow Up Notification, CS-0689.
i. Educational liaison to interact with the child/youth's educational needs and individualized educational plan;
j. Coordination of individual, group and/or family counseling/therapy by an appropriately licensed, approved or credentialed provider as clinically indicated;
k. Recreational programming; and,
l. Interdependent living training and skills building as well as coordination with DCS on interdependent post custody services.

2. The agency may access Community Clinical Services through TennCare directly:
    a. Individual therapy at least two (2) times per month but more frequently if needed, Family therapy at least monthly, Group therapy as needed. Intensive out-patient therapy and Mental Health Case management to coordinate mental health services as needed;
    b. The program must arrange access to qualified dental, medical, nursing and pharmaceutical care for service recipients of the program. child/youth or their families may choose a professional for non-emergency services;
    c. The program must insure that each child/youth has had a physical examination within the twelve (12) months prior to admission or within thirty (30) days after admission. Such examinations must include routine screenings (such as vision and hearing), and laboratory examinations (such as Pap smear and blood work) as well as immunizations as determined necessary by the physician. Also included are special studies where the index of suspicion is high and thereafter as often as indicated by the service recipient's physician. Documentation the name of the examining physician, clinic or hospital and date of examination; and,

d. As appropriate and in consultation with the child/youth's parent/guardian, the program must arrange access for each service recipient to ongoing mental health services not provided by the program and assist the service recipient in keeping appointments and participating in such treatment programs. Documentation of such referrals must be kept in the service recipient's record.

3. Emergency Services

a. The program must have an emergency protocol, including a protocol for responding to behavioral based emergencies which include contacting mobile crisis for assessments and interventions;

b. In case of medical or other type of emergencies, the program must provide respondents with immediate access to relevant information in the child/youth's record;

c. The program must provide immediate notification to the parent/guardian/legal custodian in case of emergency; and,

d. The program must complete the SIR (serious incident report) as required by DCS policy.

H. Medication Administration

1. Medication administration must be conducted pursuant to DCS Policy 20.15.
2. Medication management and medications may be arranged and accessed through TennCare and private insurance if applicable.
3. Medication management (psychopharmacological treatment) must be accessed quarterly or more often as medically necessary.

I. Education of the Child/Youth

1. Child/youth in Group Care Facilities licensed as Family Boarding Homes or Maternity Homes typically attend public school. Children/youth in residential programs licensed as Group Care Homes, Child Placing Agencies and Residential Child Care Agencies may attend public school. Regions and providers must work collaboratively through the CFTM process to determine placement options for a child/youth with zero tolerance needs. The DCS Education Specialist MUST be included in the CFTM.

   (For additional licensure information, see Section 9, Attachment 8, titled *Licensure Matrix.);*

2. Providers should meet all criteria outlined in Section 9, Attachment 9, titled *Educational Standards for DCS Providers.*
3. Group Homes providing specialty services such as Level II Special Population A&D services must have an in-house school.

J. Monitoring Progress

The agency will monitor the child/youth's progress and will enter monthly summary information in the current child welfare information system.

K. Utilization Review

1. The agency will meet the Core Standards outlined in Section 1 of the Provider Policy Manual (PPM).
2. Agency will participate in DCS Utilization Reviews (UR). UR generally occurs at 30-day intervals.

L. Discharge Criteria

Child/youth will be discharged according to the decision of the CFTM and using the CFTM protocol.

M. Recreational Activities in the Group Home Setting

The program must ensure that opportunities are provided for recreational activities. These activities, when possible and within reason, must be appropriate to, and adapted to, the needs, interests and ages of the service recipients.

N. Individual Health, Hygiene and Grooming in the Group Home Setting

1. The program must assist child/youth in the independent exercise of health, hygiene and grooming practices;
2. The program must assist each individual child/youth in securing an adequate allowance of personally owned, individualized, clean and seasonal clothes that are the correct size;
3. The program must assist and encourage child/youth in the use of dental, physical or prosthetic appliances or devices and visual or hearing aids.

O. Record Management

1. The individual record for each child/youth must contain the following information:
    a. Documentation of the Treatment Plan and the Individualized Education Program (if required) and of their implementation;
    b. Documentation of all drugs prescribed and/or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason for prescription;
    c. Narrative summary review at least every six (6) months to include all medications prescribed. This review should also include specific reasons for the continuation of each medication;
    d. Documentation of significant behavior and actions taken by staff;
    e. A list of each article of the child/youth's personal property valued at one hundred dollars ($100.00) or more and its disposition if no longer in use;
    f. Documentation of abuse, medical problems, accidents, seizures and illnesses. This documentation must include the treatment for such abuse, accidents, seizures and illnesses and any reports generated as a result of such incidents;
    g. Results of assessments required by this rule;
    h. Discharge summary detailing the child/youth's condition at the time of discharge and the signature of person preparing the summary;
    i. Documentation of an education plan developed for each child/youth that conforms to the Rules, Regulations and Minimum Standards of the State Board of Education and confirms the Individualized Education Program (IEP) test being developed by an appropriately constituted IEP-Team for all "qualified students with disabilities;"
    j. The education plan may include education services provided either by the facility or by the Local Education Agency; and,
    k. Appropriate consents and authorizations for the release and obtaining of information about the child/youth.

III. LEVEL III RESIDENTIAL TREATMENT FACILITY (RTF)

A. General Characteristics

Level 3 Residential Treatment provides a therapeutic treatment program in a 24-hour-a-day residential facility for children and youth with significant emotional and/or psychological treatment needs. Through an individualized Treatment Plan, the agency provides intensive mental health treatment, including psychiatric services when indicated and educational services.

Note: *Regardless of the type of license issued, Level 3 RTF programs serving DCS children may not operate out of single-family dwellings. These settings are not conducive to providing the more intense clinical services and structure required for this level of service.*

Psychiatric services (e.g., psychiatric evaluations, medication management) and all needed specialized mental health treatment services (e.g., alcohol and drug treatment, sexual offender treatment, mental health/behavioral treatment) are to be provided by the agency. The cost of these services is included in the per diem rate paid to the provider by DCS. Appropriate agreements with external providers must ensure that those providers will not also bill TennCare or any other insurance provider for the service as it is covered under the per diem.

Residential Treatment Facilities (RTF) must be licensed by MHDD as: **Residential Treatment Facilities, Mental Health Hospital Facilities, Residential Rehabilitation Treatment Facilities or Mental Retardation Residential Habilitation Facilities**.

B. Admission/Clinical Criteria

Child/youth will present with difficult and challenging needs/behaviors and will have an immediate need for initial short-term or intermittent stays in the RTF setting. The following criteria must be met for admission to a Level 3 residential program:

1. The child/youth has a significant mental health disorder (DSM-IV-TR) and is impaired in social, educational, familial and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction or developmental disabilities. This disorder is amenable to “psychiatric treatment” and requires mental health treatment that cannot be successfully provided at a lower level of care. The youth needs psychiatric consultation and access to physician services as well as daily supportive guidance toward stabilization;
2. The child/youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder, *not* developmental, social, cognitive or specific medical limitations;
3. The child/youth’s current living environment, family setting and extended community do not provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately);
4. The child/youth cannot achieve successful adaptation for the purpose of stabilization *at this time* without significant structure and supportive residential guidance that can only be provided through twenty-four (24) hour intervention and supervision in a highly-structured environment;
5. The child/youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting;

6. The child/youth does not require medical substance abuse treatment (e.g. detoxification) as the primary need and does not have contraindicated medical conditions that are primary and would supersede the psychiatric symptoms;
7. Child/youth may be of any adjudication type;
8. Child/youth may pose a high risk for elopement, instability in behavior and mental health status or occasionally experience acute episodes. These youth also experience persistent maladjustment of peer and other social relationships or other influencing systems which interfere with learning and social environments;
9. Children/youth with a primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation may not be appropriate unless the agency is licensed for this service type;
10. Assessment Requirements:
    a. Child and Adolescent Needs & Strengths (CANS) shall be used as a screening tool for children and youth to assist with determination if residential treatment is indicated. Prior to the CFTM, the psychologist should be consulted and the CANS (if available) thoroughly reviewed so the team will have the recommendation available for consideration in placement-related decisions;
    In order for a child or youth to be placed in a Level 3 Residential Treatment Facility, a psychologist must determine "medical necessity". This means that whenever the psychologist, based on a review of assessments and the child's history, recommends this level of care, the Child and Family Team (CFT) is expected to support this decision. Whenever a CFT cannot come to a consensus on a recommendation of medical necessity, the situation must be reviewed by Central Office clinical staff. This is intended to ensure that those children or youth who require this level of service are given every opportunity to receive it. Less intensive Level 3 services have more flexibility for the team's input, but those children or youth who demonstrate medical necessity for an RTF setting must have that level of service provided:

    Note: Items that might need to be considered for potential placement in this setting are CANS actionable items scoring a 2 or 3 on risk behaviors and behavioral emotional needs;

    b. Youth Level of Service (YLS) - Juvenile Justice youth at this level of service may have low, medium or high YLS risk levels. Youth with very high YLS risk level scores may be appropriate for admission at this level of care based on unique case circumstances following classification at a Youth Development Center or assessment in a Level 4 treatment facility
10. Provider is required to accept all referrals for children deemed to meet the need for this level of service unless the provider is at full capacity or if the provider has justified clinical documentation that indicates either a higher level of care or a Youth Development Center (YDC) placement is more appropriate. Such a scenario will require either the region or the provider to file an appeal under the CFTM appeals process.

C. Personnel

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children/youth accepted for care and services;
2. Adequate care and supervision are provided at all times to assure that children/youth are safe and that their needs are met in accordance with their developmental level, age and emotional or behavioral problems;
3. The program must be under the direct clinical supervision of a licensed mental health professional with training and/or experience in mental health treatment of children and youth;
4. Individual and family counseling/therapy by an appropriately credentialed staff;
5. Individual staff who will provide educational programs shall meet the employment standards outlined in the state Board of Education Rules, Regulations and Minimum Standards;
6. The program must maintain a written agreement with, or employ, a Tennessee-licensed physician as a medical consultant;
7. If the consulting physician is not a psychiatrist, the facility must arrange for the regular, consultative and emergency services of a licensed psychiatrist (for further details see Service Components within the per diem and Emergency Services sections below). The psychiatrist must be available for consultation with program staff, parent/guardian and/or custodian;
8. Residential Level 3 staff to child/youth ratio: 1:5 (one direct-care, awake staff for every five on-site youth) during the day and 1:8 (one direct-care, awake staff for every eight on-site youth) overnight staff. Staff persons counted in the staff-to-service recipient ratio may only be persons who are assigned to provide direct program services as described by written job description. During normal sleeping hours the program must provide one direct-care staff person on site in each building, or physically separated unit of a building in which service recipients are housed; Support staff such as clerical, housekeeping, van and bus driver staff or students involved in an onsite practicum for academic credit may not be counted in the staff-to-service recipient ratio;

   Note: For additional licensure information see Section 0940-5-37.03 Rules of Department of Mental Health and Development Disabilities.
9. The program must provide, at all times, at least one (1) on-duty staff member trained in First Aid and the Heimlich maneuver and certified in cardiopulmonary resuscitation (CPR).

D. Individualized Treatment Plan

1. Agencies will follow their licensing and/or accreditation standards for developing a Treatment Plan within the required number of days. An individual Treatment Plan must be developed and implemented for each service recipient. The individual Treatment Plan must be based on initial history and ongoing assessment of the service recipient's needs and strengths and must be completed within seventy-two (72) hours of admission **(please refer to Licensing Standard 0940-5-37-.04)**;
2. A more formalized Treatment Plan must be developed after testing and/or assessment has occurred. The Treatment Planning process must include the family and youth as per the CFTM model for collaborative planning. This must be completed within 30 days;

3. The child's Treatment Plan will include a specific strengths-based family integration/reintegration Treatment Plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, a detail of visit supervision and location of visits. The agency will work with the facility to address transportation and communication barriers. Family counseling/therapy, therapeutic support and family visits shall not be contingent on the child's behavior;
4. The Treatment Plan will also include all goals for educational issues, mental health needs (including therapy and psychiatric medications), substance use issues, physical/medical concerns and family participation in treatment;
5. The individual Treatment Plan should consider discharge goals and estimated length of stay. Discharge planning should begin at admission and be an ongoing process;
6. Documentation of the Treatment Plan and of its implementation must be kept in the service recipient record and must include the following:
    a. The service recipient's name on the Treatment Plan;
    b. The date of development of the Treatment Plan;
    c. Individual problems specified in the Treatment Plan which are to be addressed within the particular service/program component, including treatment and educational components;
    d. Individual objectives which are related to specified problems identified in the Treatment Plan and which are to be addressed by the particular service/program component;
    e. Interventions and staff responsible for addressing goals and objectives in the Treatment Plan;
    f. Signatures of the staff providing the services;
    g. Documentation of participation of service recipient and parent/guardian/legal custodian or conservator where appropriate in the Treatment Planning process. If any of the parties refuse to participate, reasons for refusal must be documented;
    h. Standardized diagnostic formulation(s), (including, but not limited to, the current Diagnostic and Statistical Manual [DSM] Axis I-V and/or ICD-9) where appropriate, and assessment documentation on file which is updated as recommended by treatment team;
    i. Planned frequency of treatment contacts; and,
    j. A plan for family involvement in the service recipient's treatment.
7. A review of the Treatment Plan must occur at least every thirty (30) days or upon completion of the stated goals and objectives and must include the following documentation:
    a. Dated signatures of appropriate staff;
    b. An assessment of progress toward each treatment goal and / or objective with revisions as indicated;
    c. A statement of justification for the level of service(s) needed, including suitability for treatment in a less restrictive environment and continued services; and,
8. The program must ensure that the following assessments are completed prior to development of the service recipient's formalized Treatment Plan:
    a. Assessment of current functioning, and a history in the following areas:
        i. Community living skills;

ii. Living skills appropriate to age;

iii. Emotional, psychological health; and,

iv. Educational level (including educational history);

b. Basic medical history and information;

c. A six (6) month history of prescribed medication, frequently used over-the-counter medication and alcohol or other drug use;

d. History of prior mental health and alcohol and drug treatment episodes; and,

e. Assessment of whether service recipient is currently eligible for special education services in accordance with the State Board of Education Rules, Regulations and Minimum Standards.

E. Service Overview & Components within the Per Diem

The agency will provide a program of group living experiences and a program of specialized services for each child/youth accepted into care.

Service Components Required of All Level 3 Residential Programs:

1. Twenty-four (24) hour awake staff;
2. Comprehensive assessment of the child to include coordination of EPSD&T screening and recommended follow-up services, updated Family Functional Assessment, academic history, Psychiatric Evaluation and Psychological Evaluation, if needed:

   Note: Unless unavoidable extenuating circumstances exist, the requested assessment should always be completed and final report made available within thirty (30) days of the date the request was made. Requestors for these assessments may include, but not be limited to, the following entities: Child and Family Team Meeting (CFTM), juvenile court personnel, the Local Education Agency (LEA) and/or Psychiatrist/Psychologist.
3. Each child/youth must have a clinical team comprised of representatives from front line staff, nursing staff, educators, therapeutic staff and a psychiatrist. The clinical team must participate in monthly documented clinical staffing for each child/youth;
4. Behavior management system emphasizing positive reinforcements;
5. Development of Individualized Crisis Management Plan, if warranted by youth behavior;
6. Utilization of a nationally-recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions.
7. Provision of recreational activities, social skills training, daily living skills and interdependent living skills. These activities must be appropriate to, and adapted to, the needs, interests and ages of the service recipients;
8. Therapeutic support group at least two (2) times per week with each session being at least one (1) hour in length and no longer than one and a half (1.5) hours. Group size is limited to a maximum of ten (10). Groups are conducted by an appropriately trained staff member with proper supervision. Group events such as community activities, recreation and milieu management do not qualify as therapeutic support groups;

9. Group counseling/therapy conducted by an appropriately credentialed staff at least three (3) times per week with each session being at least one (1) hour in length and no longer than one and a half (1.5) hours. Group size is not to exceed ten (10). These are clinically-focused groups and are specific to the specialized needs of the youth such as alcohol and drug, mental health or sexually abusive issues;
10. Individual counseling/therapy by an appropriately credentialed staff at least weekly with the session lasting at least one-half (.5) hour;
11. Family counseling/therapy:
    a. Provided by appropriately credentialed/licensed staff to the family identified as the family of care or the permanency family. This family is identified by the DCS Family Service Worker (FSW) as soon as possible after coming in to custody or upon admission to the facility. The agency therapist will have contact with the family of care or permanency family and the DCS FSW either by phone or in person within the first week of admission;
    b. Provided at a minimum of two (2) times per month unless contraindicated;
    c. Routine contacts with family and youth (visitation, phone calls) are not considered counseling/therapy;
    d. Sessions will be one (1) hour in length;
    e. Family schedules may necessitate minor changes in the length and frequency of counseling /therapy and these changes are to be documented in the case notes;
    f. Contraindications to family involvement and family counseling/therapy will be documented in the Treatment Plan. Provider concerns regarding family involvement will be addressed in writing to the DCS FSW (e-mail notification is allowed);
    g. The provider agency is responsible for working with the family to overcome barriers to involvement such as transportation and schedules;
    h. DCS FSW will assist with coordination and help to overcome barriers; and,
    i. Family counseling/therapy is not contingent on the youth's behavior.
12. The provider agency must arrange for on-site services of a psychiatrist. The psychiatrist must document face-to-face contact for psychiatric evaluation within two weeks of the date of admission. Psychiatric reviews, when appropriate, occur at least monthly and as needed thereafter for medication management;
13. All medications must be administered by licensed medical or licensed nursing personnel or a certified physician assistant practicing under a protocol approved by the medical staff. Such qualified personnel may only administer medication within the scope of an established protocol.
14. Health Services
    a. The program must arrange access to qualified dental, medical, nursing and pharmaceutical care for service recipients of the program. Service recipients or their families may choose a professional for non-emergency services;

b. The program must insure that each service recipient has had a physical examination within the twelve (12) months prior to admission or within thirty (30) days after admission. Such examinations must include routine screenings (such as vision and hearing), and laboratory examinations (such as Pap smear and blood work) as well as immunizations as determined necessary by the physician. Also included are special studies where the index of suspicion is high and thereafter as often as indicated by the service recipient's physician. Documentation of the physical examination must be placed in the service recipient's record and must include the name of the examining physician, clinic or hospital and date of examination.

15. Emergency Services:
    a. In case of medical or other type of emergencies, the program must provide for immediate access to relevant information in the service recipient's record;
    b. The program must provide immediate notification to the parent/guardian/legal custodian in case of emergency;
    c. The program must provide direct or telephone access to at least one (1) Tennessee licensed mental health professional twenty-four (24) hours a day seven (7) days a week. If the professional is not a psychiatrist, the program must also arrange for the regular, consultative, and emergency services of a psychiatrist;
    d. The program must provide back-up coverage by staff trained to handle acute psychiatric issues on a twenty-four (24) hours per day, seven (7) days per week on-call basis;
    e. The program must secure emergency services for service recipients who pose an imminent physical danger to themselves or others.
16. Individual Health, Hygiene and Grooming in the RTF Setting
    a. The program must assist service recipients in the independent exercise of health, hygiene and grooming practices;
    b. The program must assist each individual service recipient in securing an adequate allowance of personally owned, individualized, clean and seasonal clothes that are the correct size;
    c. The program must assist and encourage individual service recipients in the use of dental, physical or prosthetic appliances or devices and visual or hearing aids.

F. Education of the Child/Youth

1. The facility must have a Tennessee Department of Education and DCS-approved educational program in compliance with all necessary educational requirements including special education services, when applicable;
2. Students in residential programs licensed as **Residential Treatment Facilities, Mental Health Hospital Facilities, Residential Rehabilitation Treatment Facilities or Mental Retardation Residential Habilitation Facilities** must have an approved in-house school site available for students.

   (For additional licensure information, see Section 9, Attachment 8, titled *Licensure Matrix.);*
3. Providers should meet all criteria outlined in Section 9, Attachment 9, *titled Educational Standards for DCS Providers.*

G. Records Management

1. The individual record for each service recipient must contain the following information:
   a. Documentation of the initial Treatment Plan (within 72 hours), formalized Treatment Plan (within 30 days) and the Individualized Education Program (if required) and of their implementation;
   b. Progress notes must be recorded daily and must include written documentation of service recipient progress and changes which have occurred within the implementation of the Treatment Plan. These progress notes must be dated and include the signature, title or degree of the person providing the service;
   c. Psychological Evaluations and Psychiatric progress notes. These notes must be dated and include the signature, title or degree of the person providing the service;
   d. Documentation of all drugs prescribed and/or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason for prescription;
   e. Narrative summary review at least every six (6) months to include all medications prescribed. This review should also include specific reasons for the continuation of each medication;
   f. Documentation of significant behavior and actions taken by staff;
   g. A list of each article of the service recipient's personal property valued at one hundred dollars ($100.00) or more and its disposition if no longer in use;
   h. Documentation of abuse, medical problems, accidents, seizures and illnesses. This documentation must include the treatment for such abuse, accidents, seizures, and illnesses and any reports generated as a result. Results of assessments are required by this rule;
   i. Discharge summary which details the service recipient's condition at the time of discharge and the signature of person preparing the summary;
   j. Documentation of an education plan developed for each service recipient that conforms to the Rules, Regulations and Minimum Standards of the State Board of Education and confirms the Individualized Education Program (IEP) test being developed by an appropriately constituted IEP Team for all "qualified students with disabilities";
   k. The education plan may include education services provided either by the facility or by the Local Education Agency; and,
   l. Appropriate consents and authorizations for the release and obtaining of information about the service recipient.

H. Monitoring Progress

The agency will monitor progress and will submit monthly summaries to DCS Service Appeals Tracking (SAT) Coordinators.

I. Utilization Review

1. The agency will meet the Core Standards outlined in Section 1 of the Provider Policy Manual (PPM).
2. Agency will participate in DCS Utilization Reviews (UR). UR generally occurs at 30 day intervals.

J. Discharge Criteria

Children/youth will be discharged according to the decision of the CFTM and using CFTM protocol.

IV. LEVEL IV RESIDENTIAL TREATMENT

A. General Characteristics

1. Level IV is hospital-based residential care, which is a physician-directed level of care focused on establishing the behavioral and emotional prerequisites for functioning in the most appropriate, non-hospital environments.
2. It is a transitional level of care that a child may enter as a move towards permanency from an acute admission or as a temporary admission from a lower level of care for the purpose of emotional and/or behavioral stabilization.
3. The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, the sequence in which they are addressed and discharge recommendations.
4. The use of seclusion or restraint in Level IV programs shall be directed by a licensed independent practitioner and must be in compliance with applicable statutory, Department of Children's Services, licensure, CMS and accreditation requirements.
5. The DCS Regional Well-being Unit Psychologist must approve all admissions of children in custody to a Level IV program.
6. Psychiatric services (e.g., psychiatric evaluations, medication management) and all needed specialized treatment services (e.g., alcohol and drug treatment, sexual offender treatment) are to be provided by the agency. The cost of these services is included in the per diem rate paid to the provider by DCS. Appropriate agreements with external providers must ensure that those providers will not also bill TennCare or other insurance for the service as it is covered under the per diem.

B. Admission/Clinical Criteria

1. Level IV programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for involuntary acute psychiatric hospitalization but who continue to require specialized mental health services, which are highly structured, therapeutically intensive, and provided within a psychiatric facility.
2. The DCS FSW prepares the Referral Packet containing rationale for placement and historical data regarding a youth. The psychologist will first review all available historical, familial, psychosocial, and related clinical data (e.g., measures of psychopathology, assessment of strengths and needs) that is presented as justifying the request for admission in a secure, intense, and controlled residential treatment center at a Level IV status at this time.
3. The DCS Regional Well-being Unit Psychologist considers whether the following medical necessity criteria are met.
   a. The youth has a significantly severe mental health disorder (DSM-IV-TR or by clinical presentation) and is markedly impaired in social, educational, familial, and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction, or developmental disabilities. This disorder is amenable to "active psychiatric treatment" and requires physician-directed care that cannot be successfully provided at a lower level of care. The youth cannot be medically stable in a most appropriate setting, requires 24-hour nursing staff on site, minimum of weekly psychiatric face-to-face consultation, and daily supportive guidance toward short-term stabilization status.

b. The youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support system representatives to provide. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder *not* developmental, social, cognitive, or specific medical limitations.

c. The youth's current living environment, family setting, extended community do not provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).

d. The youth cannot achieve successful adaptation for the purpose of short-term stabilization *at this time* without significant structure and supportive inpatient guidance that can only be provided through twenty-four (24) hour per day, seven (7) day per week regimen.

e. The youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.

f. The youth does not require medical substance abuse treatment as the primary need, does not have contraindicated medical conditions that are primary and supersede the psychiatric symptoms, and/or has not been adjudicated as a sexual perpetrator who requires specialized treatment services in a unique setting.

C. Admissions Process

1. All referrals for level IV services for children in custody will be made to the Regional Well-being Unit Psychologist. The Regional Well-being Unit Psychologist will conduct a case review including, whenever possible, face-to-face interviews with the child and his or her caregiver to determine the appropriateness of Level IV services.
2. The psychologist will consult with the DCS FSW and resource manager about the appropriateness of Level IV services.
3. The psychologist, FSW and resource manager will jointly discuss the case with the Level IV provider and decide if the child is appropriate for a Level IV program. If deemed appropriate, an admission will be accomplished.

D. Personnel

1. The agency provides a physician-directed program and has available the services of a licensed physician on a 24-hour basis.
2. The agency needs to comply with DMHDD licensing regulations (for their type of licensure) regarding ratio of children to staff.
3. Depending on the needs of the children in care, the services of qualified and appropriately credentialed professionals will be available among the agency's personnel or through cooperative arrangements.
4. Residential Level 4—Provide a direct-care staffing level of at least 2 direct-care staff members on duty/on site per ward per shift with at least one (1) nurse per building per shift. Supervision by a Registered Nurse must be provided at the facility on a 24-hour per day basis.

E. Individualized Treatment Plan

1. An initial treatment plan will be developed within three (3) days of admission and reviewed with the regional psychologist. A more formalized treatment plan must be developed within seven days of admission after testing and consultation.
2. The regional psychologist will be present, in person or by telephone, at the child's initial treatment team meeting. If the regional psychologist cannot be present upon notification from the provider, he/she will be provided the opportunity for input prior to the initial treatment team meeting.
3. The child's treatment plan will include a specific strengths-based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, whether visits are supervised, and location of visitations. DCS will work with the provider to address transportation and communication barriers. Family counseling/therapy, therapeutic support and family visits shall not be contingent on the child's behavior.
4. The treatment plan also will include all goals for educational issues, mental health needs (including counseling/therapy and psychiatric medications), substance use issues, physical/medical concerns, and family support to assist in permanence/family reunification.
5. Within three (3) days of admission, a preliminary discharge plan will be drawn up through collaboration between the regional psychologist and the treatment team of the Level IV agency. This discharge plan will contain an estimate of the length of stay and discharge goals.

F. Service Components Provided within the per diem

1. Service components required of all Level IV programs:
   a. Twenty-four (24) hour awake staff;
   b. Comprehensive assessment of the child, if not current, to include coordination of EPSDT screening and recommended follow-up services, updated Family Functional Assessment, academic history, and psychological evaluation if needed;
   c. Behavior management system emphasizing positive reinforcements;
   d. Development of Individualized Crisis Management Plan, if warranted by youth behavior;
   e. Social skills training;
   f. Activity therapy;
   g. Daily living skills;
   h. Daily group therapeutic support within the context of the milieu;
   i. Group counseling/therapy conducted by an appropriately credentialed staff at a frequency determined by the treatment team. The treatment team is encouraged to include the regional psychologist in the treatment planning;
   j. Individual counseling/therapy by an appropriately credentialed staff at least twice weekly;
   k. Family therapy

      A Family of Care—biological, relative, or foster—will be identified by the family services worker, regional resource manager and Level IV staff as soon as possible following admission to the facility if the youth does not already have a family identified. This is generally the family to whom the child will return after discharge. Either in person or by telephone, the assigned therapist will meet with the Family of the Care and DCS FSW within the first week of

admission. Family counseling/ therapy will be conducted by appropriately credentialed staff at least weekly or as advised by the CFT unless there is documented reason for no family involvement.

l. Psychiatric evaluation by the treating psychiatrist within three (3) days of admission, and at least weekly contact with the psychiatrist on an ongoing basis;

m. Tennessee Department of Education and DCS approved educational program in compliance with all necessary educational requirements including special education services when applicable;

n. Nationally recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions; and

o. Specialized treatment needs identified by the treatment team or CFT that may not be generally available but are critical to the overall treatment, stability and success of the youth.

G. Education of the Child/Youth

1. Students in residential programs licensed as **Residential Treatment Facilities, Mental Health Hospital Facilities, Residential Rehabilitation Treatment Facilities or Mental Retardation Residential Habilitation Facilities** must have an approved in-house school site available for students.

   (For additional licensure information, see SECTION NINE, Attachment 8, titled Licensure Matrix.)

2. Providers should meet all criteria outlined in SECTION NINE, Attachment 9, titled Educational Standards for DCS Providers.

H. Monitoring Progress

1. Monthly Summaries will be entered directly into the system of record whenever it becomes available at 14-day intervals. In the event that the system is not available Monthly Summaries will be forwarded to the DCS Regional SAT Coordinator at 14-day intervals. The agency will provide any additional information needed for the regional psychologist to review the child's progress toward treatment goals and discharge goals at these 14-day intervals. For this review, the agency will coordinate with the regional psychologist to allow for the psychologist to participate in person or by telephone, in the child's treatment review nearest to the 14-day interval.
2. The agency will give the regional psychologist and the regional nurses access to information about psychotropic medication and seclusion and restraint instances. Level IV staff may be asked to consult with regional well-being unit staff about these issues.

I. Utilization Review

1. The agency will meet the Core Standards outlined in Section 1 of the Provider Policy Manual (PPM).
2. Agency will participate in DCS Utilization Reviews (UR). UR generally occurs at 30-day intervals.

J. Discharge Planning and Discharge Criteria

1. A preliminary discharge plan with discharge goals, projected length of stay, and tentative aftercare plan will be formulated and shared with the DCS regional psychologist, educational specialist, family services worker, and placement specialist.
2. A youth is ready for discharge when he/she no longer meets the admission criteria (outlined above) and sufficient aftercare services (e.g., mental health, education, family, medical/physical) have been arranged to allow for a smooth transition toward permanency.